**Nevada Infusion**
**5401 Longley Lane, Suite 34, Reno, NV 89511**
**PH: 775-453-0667 | Fax: 775-470-8478**

# Hyqvia Order Form

Patient Name: _____ DOB:_____

Phone:_____ Address: _____

City: _____ State:_____ Zip:_____ Email: _____

Sex: _____ Height: _____ Weight:_____ Allergies:_____

**DIAGNOSIS:**

- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ICD-10: _____
- ☐ Primary Immunodeficiency (PI) ICD-10:_____
- ☐ Other Diagnosis:_____ ICD-10:_____

**ORDER FOR HYQVIA (Immune Globulin SubQ): Hyquvia (immune globulin 10%) with recombinant human hyaluronidase 160 units per ml/vial**

**Initial Dosing:**

**For patients previously on another IG treatment, it is recommended to administer the first dose approximately one week after the last infusion (PI) or two weeks after the last infusion(CIDP) of their previous treatment.**

Previous IG Treatment: _____ Date of Last Therapy:_____

- ☐ **The patient is new to therapy, follow ramp up scheduling per Hyquvia dosing chart, then continues to maintain dose. HYQVIA 10%: _____mg/kg, every _____weeks, x1 year**

**Maintenance dose:**

- ☐ **HYQVIA 10%: _____mg/kg, every _____weeks, x1 year**

**Other Dosing:**

- ☐ **Other Dosing:_____g/kg x _____Days x1 year**
- ☑ Dispense one month of drug, premedications, RN medications, flushes, needles, syringes, and ancillary supplies, refill x 1 year

**PRE-MEDICATIONS:**

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

**MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:**

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

**PROVIDER INFORMATION:**

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

**Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478**

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **